

BEHAVIORAL OBSERVATIONS

(Check all Relevant Categories)

☐ Aggressive☐ Agitated☐ Delusional☒ Eye Contact *Poor*☐ Hallucinating☐ Hyperactivity☐ Irrational☐ Labile☐ Lethargic☐ Loose Associations☐ Manipulative☐ Paranoia☐ Passive☒ Withdrawn☐ Terrified/Crying☐ Other: _____

Comments:

MENTAL STATUS EXAMINATION

(Write in Brief Description)

Affect:

Flat

Appearance:

well groomed

Concentration:

average

Intellectual Functioning:

average

Mood:

depressed

Memory:

Poor

Orientation:

x4

Speech:

slow, soft

Other:

SUICIDE POTENTIAL SCREENING

1.	Correctional or Transporting Officer reports inmate may be suicidal risk.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2.	Experienced a significant loss within last six months. Describe: _____	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3.	Worried about major problems other than legal situation. Describe: <i>Refuses to say</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4.	Holds position of respect in community and/or alleged crime is shocking in nature.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	First involvement with legal system. Describe: _____	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
6.	Appears to feel unusually embarrassed or ashamed.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7.	Expresses feelings of helplessness or hopelessness.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
8.	Shows signs of depression: crying, <u>emotional flatness</u> Describe: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
9.	Appears overly anxious, afraid, or angry.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10.	Is acting and/or talking in a strange manner. (cannot focus attention, hallucinating)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

SUICIDE POTENTIAL SCREENING (continued)

11.	Has made previous suicide attempts. Date of most Recent Attempt: <u>1999</u> Method: <u>Cut self</u> Number: <u>4+</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
12.	Expresses thoughts of killing self.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
13.	Has a suicide plan. Describe: _____	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
14.	Has the means to carry out the suicide plan. <u>N/A</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No
15.	Family member or significant other has attempted or committed suicide. Relationship: <u>Best Friend</u> Date: <u>When in 7th grade</u> Method: <u>Gun</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
TOTAL YES/NO COUNT		Yes <u>9</u> No <u>11</u>

If there are any checks in the Behavioral Observation Section (pg. 1), or if the total yes count in Suicide Potential Screening

DISPOSITION

(check all appropriate boxes)

- ☐ Place on continuous suicide watch
☐ Place on close suicide watch
☒ Psychiatric medication order needed

REFERRAL FOR MENTAL HEALTH EVALUATION:

(check one box)

- ☐ Emergency referral (1 hr)
☐ ASAP referral (3 days)
☒ Routine referral (30 days)
☐ No referral

(check one box)

- ☐ Place in crisis/safe cell
☐ Place in special housing
☐ Place in RTU
☒ Place in general population

Mental Health Classification Assigned

- ☐ N
☐ C₁
☒ C₂
☐ C₃

Comments:

Inmate Name: markNumber: 379-989

**Initial Medical/Mental Health/Substance Use Screening**Provide information in the *Comment* section for all questions answered yes.
All information is based upon self report of inmate.

Date of Interview: 11-28-99	Signature/Title of Interviewer: P. Nicastro RN BSN	
Time of Interview: 900pm	Institution: TCT	Printed Name/Title of Interviewer: Pat Nicastro RN
Date of Arrival at Institution: 2 mos. ago	Time of Arrival at Institution:	Received from: Lucasville
Inmate Name: Woods, Bruce	Inmate Number: 329 889	

- | | | | |
|----|---|--|---|
| 1 | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | History of outpatient mental health treatment |
| 2 | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | History of inpatient treatment |
| 3 | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | History of head injury |
| 4 | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | History of violent behavior |
| 5 | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | History of suicide attempts** |
| 6 | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Current suicidal thoughts** |
| 7 | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Current suicide plan** |
| 8 | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Ability to carry out current suicide plan** |
| 9 | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | Unusual behavior/affect** |
| 10 | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Current psychotropic medications (see current medication on medical form) |
| 11 | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Hallucinations** in past at age 12-13 |
| 12 | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Was this inmate on caseload at sending institution. If discharged, give date: |

Yes responded to items with ** should be referred for either immediate attention or evaluation as dictated by the individual circumstances.

Comments:

☒ Yes ☐ No Mental health orientation information given to inmate

MENTAL HEALTH DISPOSITION (Check one or more)

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Crisis/Safe cell assignment requested |
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | Special housing assignment requested |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Routine housing requested |
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | Emergency mental health referral |

MEDICAL DISPOSITION

- | | | | | | |
|---|--|---------------------|------------------------------|--|---------------------|
| <input checked="" type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Special Needs Unit | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Emergency Transport |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Infirmiry Admission | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Routine Housing |
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | Physical Referral | | | |

SUBSTANCE USE SCREENING

- | | | |
|------------------------------|--|---|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | History of alcohol and drug problem. |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Previous alcohol and drug treatment. |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | History of alcohol and drug problem when ceasing use. |

				Date of Last Use	Method	Frequency
Alcohol	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No				
Amphetamines	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No				
Cannabis	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No				
Cocaine	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No				
Hallucinogens	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No				
Inhalants	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No				
Nicotine	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No				
Opiates	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No				
Phencyclidine	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No				
Sedatives	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No				

Frequency of Use Codes:

- 1 = Less than 12 times yearly
2 = Once per month
3 = Twice per month
4 = Once per week
5 = 2 times per week
6 = More than 3 times per week
7 = Daily
8 = Binge

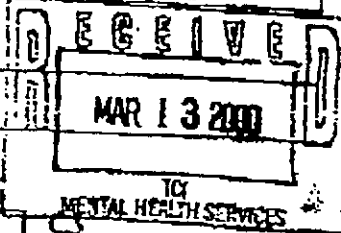
Method of Administration Coding:

- 1 = Oral
2 = Intravenous
3 = Subcutaneous
4 = Inhalation
5 = Intranasal
6 = Smoking
7 = Freebase
8 = Other

Mental Health Transfer Summary

PAGE 1/1

Inmate Name: WOODS, BRUCE Account Number: 329-889 Institution: TCF Date: 3/13/2000
 Reason for request: HANDS-ON TRANSFER
☐ Custody: change from _____ to _____ ☐ Mental Health: needs _____
☐ other _____ ☐ Program: needs _____
☐ Medical: needs _____ ☐ Classification process _____
 Current Mental Health level: ☐ N ☒ C1 ☐ C2 ☐ C3
 Psychiatric medications prescribed: ☒ Yes ☐ No
 Is this transfer outside the cluster: ☒ Yes ☐ No ☐ Do not know



Mental Health Concerns: Watch status within last 10 days: ☐ Yes ☒ No Type: _____
 ① DOES HAVE Hx of Depression. Has made verbal threats of self injury & "going off" in the past (10/99) Had 2 previous attempts in 1998 (one with no type of attempt).

Name of person completing report: Monica Borden, PC Signature of person completing report: [Signature] Date: 3/13/00
 If the transfer involves an inmate on the Mental Health caseload to be transferred to an Institution OUTSIDE the cluster, the Bureau of Mental Health Services must approve the transfer.
☒ Approved ☐ Denied Bureau of Mental Health Services: [Signature] Date: 3/14/00

Axis I: Depressive Disorder NOS Current prescribed medication: _____ Compliance (3 months)
 Axis II: Dominant

31	100	31	100	31	100
100%		93%		98%	

 Axis III: None
 Changed in last month: ☐ Yes ☒ No

Housing recommendations:
 Current mental status and summary of progress in treatment:
 ① Stable at this time. Less depressed & compliant w/ current meds.
 If transferred - should be transferred to another RTH.
 ② does not attend any groups - would benefit from group & individual counseling along w/ medication.

Signature of person completing this section: [Signature] Mental Health Manager: [Signature]
 WHITE - Inmate with transfer accepted by Bureau of Classification CANARY - File in Inmate's Mental Health file in "Screening/Evaluation/Assessment" section
 DRC 6180 (Rev. 8/98)

Mental Health Transfer Summary

Inmate Name: <u>Woods, BRUCE</u>	Inmate Number: <u>329-889</u>	Institution: <u>TCI</u>	Date: <u>3-28-2000</u>
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Reason for request:

- ☐ Custody: change from _____ to _____
- ☒ other HARDSHIP TRANSFER
- ☐ Medical: needs _____
- ☐ Mental Health: needs _____
- ☐ Program: needs _____
- ☐ Classification process
- Current Mental Health level: ☐ N ☒ C1 ☐ C2 ☐ C3
- Psychiatric medications prescribed: ☒ Yes ☐ No
- Is this transfer outside the cluster: ☒ Yes ☐ No ☐ Do not know

Mental Health Concerns: Watch status within last 10 days: ☐ Yes ☒ No Type: _____

Has history of Depression. Several months ago made threats of self-injury & "going off." Had 2 previous "attempts" reported, in 1990.

Name of person completing report: <u>A. Michael Ricciardi, Ph.D.</u>	Signature of person completing report: <u>A. Michael Ricciardi, Ph.D.</u>	Date: <u>3-28-2000</u>
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If the transfer involves an inmate on the Mental Health caseload to be transferred to an institution OUTSIDE the cluster, the Bureau of Mental Health Services must approve the transfer.

☒ Approved ☐ Denied

Bureau of Mental Health Services: <u>Chris Brown</u>	Date: <u>3/29/00</u>
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State of Ohio
Department of
Rehabilitation and Correction
**Intrasystem Transfer
and Receiving**
HEALTH SCREENING FORM

Name: <u>Woods, Bruce</u>	
Number: <u>329-889</u>	
Date of Birth: <u>10-18-66</u>	
Race: <u>B</u>	Sex: <u>M</u>

Date: <u>4/18/00</u>	Time: <u>1915</u>	Transferring Institution: <u>SOCF</u>	
Diagnosis: 1		Medications: 1 <u>Paxil 20mg qHS</u>	
2		2	
3		3	
4		4	
Allergies:		PPD mm:	PPD Date:
Current Treatments:		Diets:	
Pending Consults:		Chronic Care Clinics:	
Follow-Up Care Needed:			
Disabilities, Limitations, Prosthetic Devices:			
Presently on Suicide Watch? <input type="checkbox"/> Yes <input type="checkbox"/> No		History of Suicide Attempts? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
On Psychotropic medications? <input type="checkbox"/> Yes <input type="checkbox"/> No		Signature:	
Date: <u>4/18/00</u>	Time:	Receiving Institution: <u>WCI</u>	
SUBJECTIVE Complaints:			
Diagnosis: 1 <u>mental health hpt.</u>		Medications: 1 <u>PAXIL 20mg qHS</u>	
2		2	
3		3	
4		4	
OBJECTIVE: Physical Appearance, Behavior:			
vital signs: Temp: <u>98.8</u> Pulse: <u>84</u> Resp: <u>16</u> BP: <u>110/70</u> Weight: <u>170</u>			
ASSESSMENT:			
PLAN (Disposition): <input type="checkbox"/> Routine (Advised how to access Health Care) <input type="checkbox"/> DSC Appointment Date:			
<input type="checkbox"/> Pending Consults noted: <u>None</u>		<input type="checkbox"/> Chronic Care Clinic appointment date: <u>None</u>	
<input type="checkbox"/> Placed in infirmary	<input type="checkbox"/> Special housing	<input type="checkbox"/> Therapeutic diet ordered	<input type="checkbox"/> Work/program limitations ordered
<input type="checkbox"/> Health Education Material Reviewed		Signature: <u>A. Wolf</u>	

Intrasystem Transfer and Receiving Form



Initial Medical/Mental Health/Substance Use Screening

Provide information in the *Comment* section for all questions answered yes.
All information is based upon self report of inmate.

Date of Interview: 11/11/03 Signature/Title of Interviewer: [Signature]
Time of Interview: 11:00 AM Institution: WCI Printed Name/Title of Interviewer: [Name]
Date of Arrival at Institution: 11/11/03 Time of Arrival at Institution: 11:00 AM Received from: SCF
Inmate Name: Woods, Bruce Inmate Number: 324-887

- 1 ☒ Yes ☐ No History of outpatient mental health treatment
2 ☒ Yes ☐ No History of inpatient treatment
3 ☒ Yes ☐ No History of head injury 1995 n.t.e baseball bat.
4 ☒ Yes ☐ No History of violent behavior
5 ☒ Yes ☐ No History of suicide attempts** 1999 cut wrists
6 ☐ Yes ☐ No Current suicidal thoughts**
7 ☐ Yes ☐ No Current suicide plan**
8 ☐ Yes ☐ No Ability to carry out current suicide plan**
9 ☐ Yes ☐ No Unusual behavior/affect**
10 ☐ Yes ☐ No Current psychotropic medications (see current medication on medical form)
11 ☐ Yes ☐ No Hallucinations**
12 ☐ Yes ☐ No Was this inmate on caseload at sending institution. If discharged, give date:

Yes responded to items with ** should be referred for either immediate attention or evaluation as dictated by the individual circumstances.

Comments:

☐ Yes ☐ No Mental health orientation information given to inmate
MENTAL HEALTH DISPOSITION (Check one or more)

- ☐ Yes ☐ No Crisis/Safe cell assignment requested
☐ Yes ☐ No Special housing assignment requested
☒ Yes ☐ No Routine housing requested
☐ Yes ☐ No Emergency mental health referral

MEDICAL DISPOSITION

- ☐ Yes ☐ No Special Needs Unit
☐ Yes ☐ No Infirmary Admission
☐ Yes ☐ No Physical Referral
☐ Yes ☐ No Emergency Transport
☒ Yes ☐ No Routine Housing

SUBSTANCE USE SCREENING

- ☐ Yes ☒ No History of alcohol and drug problem.
☐ Yes ☒ No Previous alcohol and drug treatment.
☐ Yes ☐ No History of alcohol and drug problem when ceasing use.

- Alcohol ☐ Yes ☒ No
Amphetamines ☐ Yes ☒ No
Cannabis ☐ Yes ☒ No
Cocaine ☐ Yes ☒ No
Hallucinogens ☐ Yes ☒ No
Inhalants ☐ Yes ☒ No
Nicotine ☐ Yes ☒ No
Opiates ☐ Yes ☒ No
Phencyclidine ☐ Yes ☒ No
Sedatives ☐ Yes ☒ No

Date of Last Use	Method	Frequency

Frequency of Use Codes:

- 1 = Less than 12 times yearly
2 = Once per month
3 = Twice per month
4 = Once per week
5 = 2 times per week
6 = More than 3 times per week
7 = Daily
8 = Binge

Method of Administration Coding:

- 1 = Oral
2 = Intravenous
3 = Subcutaneous
4 = Inhalation
5 = Intranasal
6 = Smoking
7 = Freebase
8 = Other

DETAILED MENTAL HEALTH SCREENING FORM

MENTAL HEALTH HISTORY		
1.	History of psychotropic medications Current usage _____ List Medications _____ _____ Evidence of EPS _____	<input checked="" type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input checked="" type="radio"/> No
2.	History of psychiatric hospitalization	<input type="radio"/> Yes <input checked="" type="radio"/> No
3.	History of out-patient mental health treatment	<input type="radio"/> Yes <input checked="" type="radio"/> No
4.	History of violence: (circle those that apply) Behavior Threats Verbally Assaultive Physically Assaultive	<input checked="" type="radio"/> Yes <input type="radio"/> No
5.	History of self-injurious behavior	<input type="radio"/> Yes <input checked="" type="radio"/> No
6.	History of head injury, trauma Describe: _____	<input type="radio"/> Yes <input checked="" type="radio"/> No
7.	Length of time in country jail: ____ Years ____ Months	
8.	History of placement in any special education programs	<input type="radio"/> Yes <input checked="" type="radio"/> No
BEHAVIORAL OBSERVATION (Circle all Relevant Categories)		
Aggressive Agitated Delusional Eye Contact Hallucinating Hyperactivity	Irrational Labile Lethargic Loose Associations Manipulative Paranoia	Passive Rational Terrified/Crying Withdrawn Other _____
MENTAL STATUS EXAMINATION (Write in Brief Description)		
Affect <u>Happy</u> Concentration <u>Alert</u> Mood <u>Blended but Flat</u> Orientation <u>X 3</u> Other _____	Appearance <u>Clean</u> Intellectual Functioning <u>Ac</u> Memory <u>Intact</u> Speech <u>Clear</u>	
ODRC Health History Available		<input checked="" type="radio"/> Yes <input type="radio"/> No
Screened By <u>[Signature]</u> Date <u>7/6/97</u>	Title <u>B.D.C.</u> Time <u>1:22 PM</u>	
Reviewed by _____ Date _____	Title _____ Time _____	
Inmate Name <u>Ward</u> Institution <u>SAIF</u>	Number <u>329-889</u>	

SUICIDE POTENTIAL SCREENING		
1.	Correctional or Transporting Officer reports subject may be suicidal risk.	Yes <input type="radio"/> No <input checked="" type="radio"/>
2.	Experienced a significant loss within last six months. Describe _____	Yes <input type="radio"/> No <input checked="" type="radio"/>
3.	Worried about major problems other than legal situation. Describe _____	Yes <input type="radio"/> No <input checked="" type="radio"/>
4.	Holds position of respect in community and/or alleged crime is shocking in nature.	Yes <input checked="" type="radio"/> No <input type="radio"/>
5.	First involvement with legal system.	Yes <input type="radio"/> No <input checked="" type="radio"/>
6.	Appears to feel unusually embarrassed or ashamed.	Yes <input type="radio"/> No <input checked="" type="radio"/>
7.	Expresses feelings of helplessness or hopelessness.	Yes <input checked="" type="radio"/> No <input type="radio"/>
8.	Shows signs of depression: crying, emotional flatness Describe _____	Yes <input checked="" type="radio"/> No <input type="radio"/>
9.	Appears overly anxious, afraid, or angry.	Yes <input type="radio"/> No <input checked="" type="radio"/>
10.	Is acting and/or talking in a strange manner. (Cannot focus attention, hallucinating)	Yes <input type="radio"/> No <input checked="" type="radio"/>
11.	Expresses thoughts of killing self.	Yes <input type="radio"/> No <input checked="" type="radio"/>
12.	Has made previous suicide attempts. Number <u>2</u> Date of Most Recent Attempt <u>95</u> Method <u>OB</u>	Yes <input checked="" type="radio"/> No <input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/>
13.	Has a suicide plan. Describe _____	Yes <input type="radio"/> No <input checked="" type="radio"/>
14.	Has the means to carry out the suicide plan.	Yes <input type="radio"/> No <input checked="" type="radio"/>
15.	Family member or significant other has attempted or committed suicide. Relationship _____ Date _____ Method _____	Yes <input type="radio"/> No <input checked="" type="radio"/>
TOTAL YES/NO COUNT		<u>5/10</u>
If there are any circles in shaded areas, or if the total yes count is six or more, review for special watch status and refer for mental health evaluation.		
DISPOSITION		
<input checked="" type="checkbox"/>	Approved for general population; no mental health referral	
<input type="checkbox"/>	Approved for general population; routine mental health referral	
<input type="checkbox"/>	Special Housing - ASAP mental health referral	
<input type="checkbox"/>	Suicide precaution procedures - emergency mental health referral	
<input type="checkbox"/>	Psychiatric medications order needed	

INTER-DISCIPLINARY TREATMENT PLAN
Mental Health Services

Inmate Name: Bruce Woods	Inmate #: A-329-889
DOB: 10/18/1966	Gender: Male
Race: Black	MH Level: C2
EDS Date: / /	Original DR&C Date: 06/25/1996
Institution Date: 04/18/2000	Projected Parole Date: / /
Date of this Plan: 05/11/2000	Next Review Date: 08/11/2000

Axis I: 1. Depressive Disorder NOS 311
2. Alcohol Abuse 305.00

Axis II: 1. Personality Disorder NOS 301.9
2. Antisocial Personality Features

Axis III: (No Diagnosis) V71.09

Axis IV: Incarceration

Axis V (Current): 40

Axis V (Highest): 40

Drug(s) of Choice: Alcohol

Therapeutic Assets: Intelligent

Current Psychotropic Medications: Paxil

**Master Treatment Plan, Mental Health Services
Problem Listing Section**

Active PSYCHIATRIC Problems:

Problem #1

Problem Status: Active

PROBLEM: Inmate Woods obtains attention through self-mutilating behavior.

This problem was evidenced by:

1. Reports from non-custody staff
2. Patient's social history
3. Patient's own report
4. Medical history and physical
5. Inter-disciplinary progress notes

GOAL: Inmate Woods will use alternative ways of obtaining attention, other than self-harmful behavior, and will be able to discuss these alternatives in therapeutic sessions.

No. ---	Objective: -----	Intervention: -----	Target Dates: -----
1A	Inmate Woods will practice positive attention-seeking behavior in the group setting.	Kim Demeter L.S.W. will offer monthly groups where Inmate Woods may receive positive reinforcement for active participation.	08/09/2000
1B	Inmate Woods will be able to describe the effects of his behavior on others and will make short-term (weekly) commitments to change behavior by using problem-solving techniques.	Kim Demeter L.S.W. will provide one 30 min session to focus on behavioral insight, behavior change, and problem-solving skills.	08/09/2000

Discharge Criterion: Inmate Woods will discontinue self-mutilating behavior and will be able to obtain attention in positive and appropriate ways.

Master Treatment Plan, Mental Health Services
Problem Listing Section

Problem #2

Problem Status: Active

PROBLEM: Inmate Woods experiences symptoms of depression including ,
which interfere with his daily life.
This problem was evidenced by:
1. Reports from non-custody staff
2. Patient's own report
3. Inter-disciplinary progress notes

GOAL: Inmate Woods's symptoms will diminish to the point that his
daily functioning will no longer be affected, and he will be
able to remain in general population housing.

No. ---	Objective: -----	Intervention: -----	Target Dates: -----
2A	Inmate Woods will be able to accurately state the name, dose, effects and side effects of his medication.	Sagi Raju, M.D. will provide medication to help manage depression with review/ reassessment monthly. Psychiatric Nurse will teach Inmate Woods about the effects of his medicine in at least 1 group or individual session, and will provide compliance counseling as needed.	11/07/2000
2B	Inmate Woods will be able to describe some alternative methods of relieving depression which he may use in addition to medication.	Psychiatric Nurse will teach Inmate Woods about lifestyle choices that may impact mood in Wellness Group, monthly. Kim Demeter L.S.W. will address alternative methods of relieving depression during monthly contact visits.	11/07/2000
2C	Inmate Woods will verbally and/or non-verbally identify and express his emotions, feelings and/or opinions in a healthy manner.	Kim Demeter L.S.W. will address expression of emotions during individual sessions, monthly.	08/09/2000

Discharge Criterion: Inmate Woods's objective symptoms will diminish and he will report feeling better.

Master Treatment Plan, Mental Health Services
Problem Listing Section

Patient Agreement:

I have had the opportunity to participate in the development of this mental health treatment plan, and consent to the treatment described herein.

✓ Woods 329889

Bruce Woods, Inmate
A-329-889

5-17-2000

Date

I agree with this plan, with the following exceptions(s):

Signatures of the Interdisciplinary Team:

S. Raju MD

Sagi Raju, M.D., Psychiatrist

Psychiatric Nurse Psychiatric Nurse

Kim Demeter LSW

Kim Demeter L.S.W., Mental Health Liaison

TREATMENT PLAN REVIEW

Scheduled Review Date:	Date of Review:
11/29/99	11/29/99

Notes: I report y hat mood calm and cooperative. I report doing "alright" today. Mr. Woods reports that his depression is "alright." I denied s/i hi or A/V medication at present. I reports that he was placed on watch this weekend because he told Dr. King & sometimes he thinks about what it would be like not to be here" -- meaning "to be dead." reports that since it's now the time to commit suicide -- due to holidays -- X. I can't sign due to cage.

f Members Present: Kibby, J. P. Prouitt

Scheduled Review Date:	Date of Review:
11/30/99	11/30/99

Notes: Underlying hostility. Unwilling to share feelings. Difficult, not wanting to interact team. That Mr. informed @ he seemed offer him to other psychiatric treatment. Refused to take responsibility for being on watch.

@ ended.

f Members Present: M. Garcia, R. S. L. G.

Scheduled Review Date:	Date of Review:
12/1/99	12/1/99

Notes: I report doing "alright" today. I denied s/i hi or A/V hallucinations. I denied contact good. Treatment plan processed para notes yet I compliance with treatment in the RTU. No c/o.

Woods 329999

f Members Present: Kibby, J. P. Prouitt, V. Prouitt, J. L. G.

Inmate Name:	Inmate Number:
WOODS, Bruce	328-889

5195 (Rev. 12/97)
4349, 4351, 4354, 4355

TREATMENT PLAN

Name: <u>Wanda, Bruce</u>		No.: <u>329-889</u>		Treatment Coordinator: <u>R. Light M.S.Ed. m.H. Liaison</u>	
Diagnosis: <u>Depression N.O.S.</u>		Axis IV: <u>incarceration</u>		Date/Status (A or C or R):	
Axis V: <u>deferred</u>		Axis V: <u>current GAF 60</u>		Target Date: <u>12/2000</u>	

Problem No.	Problem	Goals/Objectives	Interventions/Frequency	Staff Responsible	Target Date	Date/Status (A or C or R)
40199-0 799	depression x 2 risk for self-harm w/ suicide attempts x 2	<p>1. I will manage depressive symptoms monitor suicidal thoughts and report them to mental health staff.</p> <p>2. I will become active in structured programming to depression.</p>	<p>1. m.H. staff will monitor potential self-harm and educate on depression management tools.</p> <p>2. group counseling mod. see will engage in structured group activities.</p>	<p>psychiatrist</p> <p>psych. nurses</p> <p>m.H. Liaison</p>	12/2000	

Check here if continued on reverse. ☐

Signature and Title:	Signature and Title:	Signature and Title:
<u>S. Kym</u>	<u>R. Light M.S.Ed. m.H. Liaison</u>	<u>J. Parrott, Act. Ther.</u>

Participated in the formulation of this treatment plan. Although this is not a legally binding contract, I realize that failure to participate in the activities could result in suspension or removal from specific treatment activities.

Wanda 329117
Patient Refused to Sign
(Rev. 12/97)

Witness Signature and Title: R. Light M.S.Ed. mental Health Liaison
Institution: TCJ
Date: 12-10-97
Status: A = Attended
C = Cancelled
R = Revised

TREATMENT PLAN REVIEW

Scheduled Review Date:	Date of Review:
12/6/99	12/6/99

Notes: Depressed "abruptly." I continues to report difficulty sleeping. I denied si/h or SV hallucinations. I reports feeling less depressed. I direct ears blunked, mood calm and cooperative. Team processed history of I advancing to level III. No specific clo.

Woods 329889

Staff Members Present: Rishy, V. Pinowitt, S. S. Seara, D. M. Hene

Scheduled/Review Date:	Date of Review:
12/22/99	12/22/99

Notes: I aspect blunked, mood unimpaired. I denies si/h or SV hallucinations. I reports sleeping "a couple of hours here and there" -- he reports idenies depression despite asher. I answers all questions in monosyllabic form -- difficult to engage in conversation.

X Woods 329889

Staff Members Present: Rishy, S. S. Seara, D. M. Hene, V. Pinowitt

Scheduled Review Date:	Date of Review:
1/3/00	1/3/00

Notes: I aspect/mood appropriate. I denied during T team. I denies si/h or SV hallucinations. I reports more active in group participation: I increased advancing to level IV.

Woods 329889

Staff Members Present: Rishy, S. S. Seara, D. M. Hene, V. Pinowitt, T. Oachoffene

Inmate Name:	Inmate Number:
WOODS, BRUCE	329-889

5198 (Rev. 12/97)
4349, 4351, 4354, 4355

TREATMENT PLAN REVIEW

Notes:	Scheduled Review Date:	Date of Review:
<p>Expect blunk, mood depressed though less than last year. I denies depression however. I denies si/hi or any hallucinations. I reports that he declines activities for outside recreation due to cold weather. I housed in segregated, awaiting resolution. No specific cell.</p>	1/24/2000	1/24/2000
Members Present: Bishop, U. Puonett, J. Miller		
Notes:	Scheduled Review Date:	Date of Review:
<p>Expect mood pleasant today. I denies si/hi or any hallucinations. I denies depression or problems interacting with peers. Treatment team processed issue to I advised level III. I was informed of the need for him to participate in anger management classes to maintain level III. I agreed to this parameter. No specific complaints voiced.</p> <p>Woods 329889</p>	2/9/2000	2/9/2000
Members Present: P. Bishop, S. [Signature]		
Notes:	Scheduled Review Date:	Date of Review:
<p>Affect brighten. Inmate Woods waiting for a transfer to Warren. Denies problems with others. Status parole is helping. Denies depression, SI, HTI. Sleep & appetite "ok". X Woods 329889.</p>		2/26/00
Members Present: P. Nivastoe R.N., Cto [Signature]		
Inmate Name: Woods, Bruce		Inmate Number: 329-889

TREATMENT PLAN REVIEW

[illegible]

WUAS 0671-007

TREATMENT PLAN REVIEW

Minutes: ① is no longer on medication. ① denies depressive symptoms. ① participates only minimally in treatment with MHL and Psychiatrist. ① maintains there is nothing wrong with him and wants to be DIC from caseload.	Scheduled Review Date: 8/2/00	Date of Review: 8/17/00
Staff Members Present: <u>Joe Demerle SR</u> <u>S Raju MD</u> <u>R. P. (A.)</u> <u>X W. 327187</u>	Scheduled Review Date: <u>8/2/00</u>	Date of Review: <u>8/17/00</u>
Minutes:		
Staff Members Present:		
Minutes:	Scheduled Review Date:	Date of Review:
Staff Members Present:		
Minutes:		
Staff Members Present:		
Inmate Name:	Inmate Number:	

Mental Health Level of Care Determination

Inmate Name: <u>Woods</u>	Number: <u>329-889</u>	Institution: <u>WCI</u>	Date: <u>8/28/00</u>
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☐ Initial☒ Annual Review☐ Update

C1 Categorical (SMI)	<input type="checkbox"/> 290.XX Dementia	<input type="checkbox"/> 295.XX Schizophrenia	<input type="checkbox"/> 295.40 Schizophreniform D/O
	<input type="checkbox"/> 295.70 Schizoaffective	<input type="checkbox"/> 296.2X MDD Single, Severe	<input type="checkbox"/> 296.3X MDD, Recurrent
	<input type="checkbox"/> 296.XX Bipolar D/O	<input type="checkbox"/> 297.1 Delusional D/O	<input type="checkbox"/> 298.X Brief Psychotic or NOS
	<input type="checkbox"/> 318.0 Moderate MR		

C1 Functional (SMI)	<input type="checkbox"/> 296.XX Mood Disorders	<input type="checkbox"/> 300.XX Panic D/O	PLUS (One of the following within the past 2 years)
	<input type="checkbox"/> 300.00 Anxiety D/O NOS	<input type="checkbox"/> 300.02 GAD	
	<input type="checkbox"/> 300.3 OCD	<input type="checkbox"/> 300.4 Dysthymic D/O	
	<input type="checkbox"/> 309.81 PTSD	<input type="checkbox"/> 301.83 Borderline P.D.	

☐ 2 Prior Psychiatric Hospitalizations
☐ 1 OCF Hospitalization > 45 Days
☐ RTU > 60 Days

C2	<input type="checkbox"/> 291.X ETOH	<input type="checkbox"/> 292.X Substance Related D/O	<input type="checkbox"/> 293.X Psychosis or Mood D/O 2* Medical
	<input type="checkbox"/> 294.X Memory or Cognitive D/O 2* Medical or NOS	<input type="checkbox"/> 296.X Mood Disorder	<input type="checkbox"/> 300.XX Panic D/O
	<input type="checkbox"/> 300.00 Anxiety D/O NOS	<input type="checkbox"/> 300.02 GAD	<input type="checkbox"/> 300.3 OCD
	<input type="checkbox"/> 300.4 Dysthymic D/O	<input type="checkbox"/> 302.X Paraphilia on Meds	<input type="checkbox"/> 309.XX Adj. D/O on Meds
	<input type="checkbox"/> 309.81 PTSD	<input type="checkbox"/> 311 Depressive D/O NOS	<input type="checkbox"/> 301.83 Borderline PD

C3	<input type="checkbox"/> 300.XX Panic D/O	<input type="checkbox"/> 300.00 Anxiety D/O NOS	<input type="checkbox"/> 300.02 GAD
	<input type="checkbox"/> 300.3 OCD	<input type="checkbox"/> 300.4 Dysthymic D/O	<input type="checkbox"/> 301.XX Personality D/O
	<input type="checkbox"/> 302.X Paraphilia	<input type="checkbox"/> 307.8X Panic D/O with Psychology/Medical	<input type="checkbox"/> 308.X Acute Stress D/O
	<input checked="" type="checkbox"/> 309.XX Adjustment D/O	<input type="checkbox"/> 309.81 PTSD	<input type="checkbox"/> 311 Depressive D/O NOS
	<input type="checkbox"/> 312 Impulsive Control D/O		

N

No Mental Health Services Needed

SO

Sex Offender Services

Printed Name of Licensed Person Completing Review:

D. Washington, Ph.D.

Signature:

[Signature]

Referral to Mental Health Services

Inmate name: <u>Woods</u>	Number: <u>329-889</u>	Date of Referral: <u>9/6/00</u>
Job:	Lock: <u>3C</u>	Unit: <u>3C</u>

Urgency Level: ☐ Routine ☐ ASAP ☒ Urgent

Reason for Referral:

(F) is asking to talk w/ Dr. Roje or someone else. Very irritated.

Referred by: <u>CO Walker (?)</u>	
Title: <u>Corrections officer</u>	Phone Ext.: <u>3400</u>

Response: (I) seen 9/6/00.

Mental Health Staff Signature: <u>[Signature]</u>	Date of Response: <u>9/6/00</u>
Supervisor Signature: <u>[Signature]</u>	



Mental Health Services

Recommendation For Discharge From The Mental Health Caseload

Inmate Name: Woods Number: 329-889

All recommendations must be supported by documentation on Interdisciplinary Progress Notes.

Treatment Coordinator Recommendation:

The above named inmate has been evaluated, and recommendation is made to discharge this inmate from the mental health caseload.

Summary Statement in Support of Recommendation:

① diagnosis is adjustment D/O with depressed mood. Medication was discontinued 6/1/00 and ② remains stable. ③ participation in treatment has been minimal and it appears he is receiving little to no benefit from Mental Health Services. No 70 day follow up required.

Kimberly Denker Social Worker II 9/6/00
Name Title Date

Psychiatric Consultation:

☒ I concur with the above recommendation (Reduce to P1A Status)

☐ I do not concur with the above recommendation

Comments: Doing fairly well 5 medication. stable
pt requesting D/C from case load.

S. Ray MD 9/12/00
Psychiatrist Signature Date

Follow up: (70 days after Psychiatric Consultation)

☐ This inmate may be discharged from the mental health caseload (Reduce to P1 Status)

☐ This inmate should be maintained on the mental health caseload

Comments:

Name Title Date

<p>WOODS 329-889</p> <p><i>M. R.</i> 6/1/00 0920H</p> <p>Ward: _____ RN: _____ Date: _____ Time: _____</p>		<p>Prob. No. _____ Date: 6-1-00 Time: 9:15 AM</p> <p>DC Panel (Pr non-compliance for a month)</p> <p>Signature: <i>S. R. R. MD</i></p>		<p>1</p> <p>DOCTOR'S ORDERS</p>	
<p>WOODS 329-889</p> <p><i>M. R.</i> 5/2/00 1130H</p> <p>Ward: _____ RN: _____ Date: _____ Time: _____</p>		<p>Prob. No. _____ Date: _____ Time: 2:30 P</p> <p>Renal Panel 20m 1+2m 3 months</p> <p>Signature: <i>S. R. R. MD</i></p>			<p>4</p> <p>DOCTOR'S ORDERS</p>
<p>WOODS 329-889</p> <p><i>M. R.</i> 5/2/00 1130H</p> <p>Ward: _____ RN: _____ Date: _____ Time: _____</p>		<p>Prob. No. _____ Date: 5/4/00 Time: _____</p> <p>_____</p>			
<p>WOODS 329-889</p> <p><i>M. R.</i> 5/2/00 1130H</p> <p>Ward: _____ RN: _____ Date: _____ Time: _____</p>		<p>Prob. No. _____ Date: _____ Time: _____</p> <p>_____</p>			<p>2</p> <p>DOCTOR'S ORDERS</p>
<p>WOODS 329-889</p> <p><i>M. R.</i> 5/2/00 1130H</p> <p>Ward: _____ RN: _____ Date: _____ Time: _____</p>		<p>Prob. No. _____ Date: _____ Time: _____</p> <p>_____</p>			
<p>WOODS 329-889</p> <p><i>M. R.</i> 5/2/00 1130H</p> <p>Ward: _____ RN: _____ Date: _____ Time: _____</p>		<p>Drug Sensitivity</p> <p>Prob. No. _____ Date: _____ Time: 7:20 P</p> <p>_____</p> <p>Signature: _____</p>		<p>1</p> <p>DOCTOR'S ORDERS</p>	
<p>WOODS 329-889</p> <p><i>M. R.</i> 5/2/00 1130H</p> <p>Ward: _____ RN: _____ Date: _____ Time: _____</p>		<p>_____</p>			